

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING

MAIL TO:
UNISYS

P.O. BOX 91021
BATON ROUGE, LA 70821

(800) 473-2783
(225) 924-5040 (IN BATON ROUGE)

LONG TERM CARE
PATIENT LIABILITY ADJUSTMENT FORM

1 PROVIDER NO.	2 RECIPIENT I.D. NUMBER	3 RECIPIENT LAST NAME	4 FIRST NAME		
5 LEVEL OF CARE	6 INITIATED BY BHSF LOCATION:				
7 FROM DATE OF SERVICE	8 TO DATE OF SERVICE	9 TOTAL DAYS	10 INTERNAL CLAIM CONTROL NUMBER (ICN)	11 REVISED MONTHLY PATIENT LIABILITY	12 STATUS

13 NAME OF BHSF REPRESENTATIVE _____ DATE _____

14 CONTACT PHONE NUMBER _____

NOTE: This form can be completed and submitted only by a BHSF representative.